

ARBN 077 464 101

ABN 94 077 464 101

www.homeopathyoz.org

## Membership renewal 2024-2025

## Due by 30 June 2024

Postcode:

Mobile:

## Member details

Cardholder name:  Signature:  Professional member (registered with ARoH)  I request that my clinic details be included on the AHA website & referral listings for access by the public.  NOTE: Clinic name and street address will not be published. NO AHA CHARGES apply for additional clinics.  Clinic 1 details:  Clinic 2 details:  Clinic name:  Clinic name:					
Full residential address: Full postal address: Telephone: Mobile: Fax: Email: Please tick if you DO NOT grant permission to the AHA to contact you by email. Professional members: please tick if you DO NOT grant permission to the AHA to update AROH with any changes to you contact, clinic, insurance or first aid certificate details in the case that you notify the AHA of such changes. In the event of my admission as a member, I agree to be bound by and observe the provisions of the Association's policies and by-laws. I declare that I have not been convicted of an indictable offence and I am not insolvent. In the case of professional membership, I declare that I do not have an impairment that affects my ability to practise in the profession. I agree to be bound by:  - the AHA's Code of Ethics & Practice (CoEP), as published on the AHA website: https://homeopathyoz.org:  - the Australian laws and provisions regulating CM professions, including those formulated by the Therapeutic Goods Administration (TGA) as published on the TGA website:  - the National Code of Conduct for Unregistered Health Practitioners applicable in my State.  - the National Code of Conduct for Unregistered Health Practitioners applicable in my State.  - the National Code of Conduct for Unregistered Health Practitioners applicable in my State.  - the National Code of Conduct for Unregistered Health Practitioners applicable in my State.  - the National Code of Conduct for Unregistered Health Practitioners applicable in my State.  - the National Code of Conduct for Unregistered Health Practitioners arising in respect to breaches of the AHA's complair and disciplinary procedures and penalties that may be immosed.  - the Intermited Processional member of the AHA website until payment is received.  - National Intermited Processional Conduct issues arising in respect to breaches of the AHA's complair and disciplinary procedures and penalties that may be immosed.  - I certify that the information supplied by me in this membership application is true an	Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr	☐ Other Gend	der: Date	of birth:	
Full postal address:  Telephone:	First name: Middle nam	e: Surname:			
Telephone: Mobile: Fax:  Email:    Please tick if you DO NOT grant permission to the AHA to contact you by email.     Professional members: please tick if you DO NOT grant permission to the AHA to update ARoH with any changes to yo contact, clinic, insurance or first aid certificate details in the case that you notify the AHA of such changes.    In the event of my admission as a member, I agree to be bound by and observe the provisions of the Association's policies and by-laws. I declare that I have not been convicted of an indictable offence and I am on tinsolvent.  In the case of professional membership, I declare that I do not have an impairment that affects my ability to practise in the profession. I agree to be bound by:  - the AHA'S Code of Ethics & Practice (CoEP), as published on the AHA website: <a href="https://homeopathyoz.org">https://homeopathyoz.org</a> ;  - AROH'S Code of Ethics & Practice (CoEP), as published on the AHA website: <a href="https://homeopathyoz.org">https://homeopathyoz.org</a> ;  - AROH'S Code of Professional Conduct and Standards of Practice;  - the Autorial naws and provisions regulating CM professions, including those formulated by the Therapeutic Goods Administration (TGA) as published on the TGA website; - the National naws and provisions regulating CM professional respect to breaches of the AHA CoEP, or any of the above; disciplinary action or deregistration by AROH; or complaints made against me; I will be subject to the AHA's complair and disciplinary procedures and penalties that may be imposed.  I certify that the information supplied by me in this membership application is true and correct:  Signature:    Date:   Date:   Date:	Full residential address:				
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